The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/dentalboard

INITIAL LIMITED LICENSE FACULTY LICENSE APPLICATION & INSTRUCTIONS

(As required pursuant to 234 CMR 4.00)

A Limited License Faculty License allows a full-time faculty member to perform all the duties of a dentist but only at a specifically-named community health center, hospital, school, dental clinic or prison facility. Private practice is prohibited. Limited License Faculty Licenses are not available to part-time faculty members and are valid for one year from the date of issue and may be re-applied for annually. The following documentation is required for initial licensure:

- An accurate, complete, signed and notarized application.
- Payment of the non-refundable, non-transferable licensing fee.
- Proof satisfactory to the Board that the applicant has been awarded a degree in dentistry. Graduates of non-CODA accredited dental schools or foreign dental schools shall submit an original transcript from a reputable dental college, including the college seal, that indicates the date of graduation and degree awarded. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental school transcript demonstrating the applicant was awarded a dental degree from a reputable dental college.
- Full-time faculty members shall submit an original letter from their employer that confirms the applicant's status as a full-time faculty member and includes the date of their appointment. The application shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M.G.L. c. 112, § 45 and be in good standing with the Board.
- Proof of current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED), or the American Heart Assoc. Basic Life Support for Healthcare Providers (BLS), or ACLS/PALS.
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English proficiency.
- A written statement that is the result of a physical examination, conducted within one year of the date of application, attesting to the health of the applicant and to any impairments which may affect the ability of the applicant to practice dentistry.
- If applicable, certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A current resume, curriculum vitae or practice history, if applicable.
- An original report from the National Practitioner Data Bank (NPDB) Self-query.

- A statement disclosing any disciplinary action, civil, and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@state.ma.us to request a copy of the exam.
- A color photograph (passport-sized or larger)

PLEASE NOTE:

- Incomplete applications will delay licensure processing.
- Please retain a copy of all application documents for your records.
- Confirmation of your license status will be available under "Check a License" on our website www.mass.gov/dph/dentalboard as soon as your licensure application is approved and your license is issued.

For information on employment opportunities, please contact the following:

Hospitals	www.mahospitalcareers.com
Community Health Centers	www.massleague.org
Massachusetts Department of Corrections	www.mass.gov/doc
Harvard School of Dental Medicine	www.hsdm.harvard.edu
Boston University School of Dental Medicine	www.bu.edu/dental
Tufts University School of Dental Medicine	www.tufts.edu/dental

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BOARD USE ONLY

Receipt #_____

Fee: _____

Jurisprudence: Pass _____ Fail _____

APPLICATION FOR INITIAL LIMITED LICENSE FACULTY LICENSE

1. APPLICANT NAME: _____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME: _____

3. HOME ADDRESS: _____
(Street) (City or Town) (State or Country) (Zip Code)

_____

Please Note: All limited licenses are issued in the name of the licensee but are mailed to the supervising dentist at address of the sponsoring institution.

4. MOST RECENT PREVIOUS ADDRESS: _____

5. TELEPHONE NUMBER: Day: _____ Cell: _____

6. EMAIL ADDRESS: _____

7. _____/_____/_____ _____ _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: ____ Feet ____ Inches WEIGHT: ____ Lbs. MOTHER'S MAIDEN NAME: _____

8. SOCIAL SECURITY NUMBER (SSN) (**disclosure is mandatory**): _____/_____/_____
Pursuant to M.G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue (DOR). The DOR will use your SSN to ascertain whether or not you are in compliance with all Massachusetts tax laws pursuant to M.G.L. c. 62C, s. 47A and child support laws pursuant to M.G.L. c. 119A, s.16.

EDUCATION

9. GRADUATE OF: _____
Name of Dental School

_____
Street City State/Province Postal Code Country

10. DATE DENTAL DEGREE CONFERRED DATE _____ DEGREE_____
MM/DD/YYYY

AN OFFICIAL TRANSCRIPT CONFIRMING THE ABOVE INFORMATION MUST BE INCLUDED.

IF APPLICABLE, AN ACADEMIC CREDENTIALS EVALUATION MAY ALSO BE REQUIRED.

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

11. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS, INCLUDING PROFESSIONS OTHER THAN DENTISTRY, WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application**.**

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR REGISTRATION IN ANY OTHER STATE OR JURISDICTION.**

☐ **I CURRENTLY HOLD A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

Issuing Jurisdiction	Profession	License/Certification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRACTICE LOCATION(S)

12 (A). NAME OF SPONSORING INSTITUTION/CLINIC _____

ADDRESS _____

PHONE: _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE # DN _____

I HEREBY ATTEST THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE _____

12 (B). OTHER AFFILIATED PRACTICE LOCATION _____

ADDRESS _____

PHONE _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN _____

I HEREBY ATTEST THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE _____

12 (C). OTHER AFFILIATED PRACTICE LOCATION _____

ADDRESS _____

PHONE _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN _____

I HEREBY ATTEST THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE _____

MASSACHUSETTS DENTAL LICENSE #DN _____

ATTESTATION OF COMPLIANCE WITH 234 CMR 4.05(5) EDUCATION REQUIREMENTS

13. CHECK THE APPLICABLE BOX BELOW. THEN SIGN TO INDICATE YOUR ATTESTATION OF THE CHECKED STATEMENT. THE SIGNATURE OF THE SUPERVISING DENTIST IS ALSO REQUIRED ON THIS PAGE.

☐ I hereby attest that I have completed or shall complete, within one year of the date of initial licensure, all of the following continuing education units (CEUs):

A minimum of 3 CEUs in the *CDC Guidelines for Infection Control*;
A minimum of 3 CEUs in OSHA Standards at 29 CFR;
A minimum of 6 CEUs in treatment planning and diagnosis;
A minimum of 3 CEUs in record-keeping;
A minimum of 2 CEUs in risk management; and
A minimum of 3 CEUs in pharmacology with emphasis on prescription writing;

OR

☐ I hereby attest that I am enrolled in a CODA-accredited dental school academic program that includes <u>all</u> areas of study listed above.

_____ _____
NAME OF SCHOOL GRADUATION YEAR

REQUIRED SIGNATURES:

_____
SIGNATURE OF APPLICANT

_____
SIGNATURE OF SUPERVISING DENTIST AS WITNESS TO APPLICANT'S ATTESTATION

_____
DATE

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES AND PROVIDE ALL RELEVANT DOCUMENTATION INCLUDING THE FINAL DISPOSITION OF ANY CRIMINAL CHARGES OR DISCIPLINARY ACTION BY ANOTHER LICENSING BOARD.

14. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

16. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

18. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of $100 or less was imposed.

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Massachusetts Board of Registration in Dentistry (Board) any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, regarding the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing my practice as a licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a dentist shall be deemed no longer valid if the requirements for licensure as a dentist are not met within one (1) year from the date the Board receives my application. I also understand that all licensure fees are non-refundable and non-transferable.

I hereby attest that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board to deny the issuance of a license, to suspend or revoke a license issued to me, and to deny the renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and Notary Public.

APPLICANT SIGNATURE _____

PRINTED NAME _____

DATE _____

Attach a recent color photo (passport sized or larger)

NOTARY NAME**:** _____

COMMISSION EXPIRES: _____ [Seal or Stamp]

DO NOT FORGET TO INCLUDE A CHECK OR MONEY ORDER FOR THE NON-REFUNDABLE AND NON-TRANSFERABLE LICENSURE FEE OF $90 (PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS).

ATTACHMENT CHECKLIST

☐ **Attachment 1: Licensing Fee –** A personal check, business check or money order payable to the Commonwealth of Massachusetts in the amount of $90. All fees are non-refundable and non-transferable. Please do not staple your payment to the application or submit cash.

☐ **Attachment 2: Proof of Graduation** – An original transcript with school seal indicating the degree awarded and date of graduation. Photocopies of transcripts are not acceptable.

☐ **Attachment 3: English Language Proficiency -** If your dental degree is from a school where instruction (written or oral) was in a language other than English, documentation of a minimum score on the TOEFL or the academic format IELTS must be included.

Test of English as a Foreign Language (TOEFL) **90** (internet-based) **or 577** (paper-based)

OR

Academic Format International English Language Testing System (IELTS**)** **7.0**

☐ **Attachment 4: Physician's Statement** – An examination and statement from your primary care provider, nurse practitioner or physician's assistant certifying that you are medically cleared to practice dentistry. The examination must be completed within the previous 12 months of your licensure application.

☐ **Attachment 5: Proof of your current certification in CPR/AED for the Professional Rescuer, Basic Life Support for Healthcare Providers (BLS) or ACLS/PALS is required.** Include a copy of both sides of your certification card with your application.

☐ **Attachment 6: Massachusetts Dental Ethics and Jurisprudence Exam -** Answer sheet only. You may keep the copy of the actual exam.

☐ **Attachment 7: Confirmation of Full-Time Faculty Appointment -** An original letter signed by a school official on institutional stationery including the date of faculty appointment.

☐ **Attachment 8: Proof of the successful completion of a Board-approved continuing education course on safe and effective opioid prescribing/pain management.** Refer to the Board's website at www.mass.gov/dph/dentalboard for info on how to access Board-approved courses; click on the link for "Alerts" then "PMP & Mandatory Educational Requirements for Prescribers."

☐ **Attachment 9: Proof of registration with MassHealth as an Ordering, Referring and Prescribing Provider.** Refer to the enclosed literature regarding MassHealth's registration requirements.

IF APPLICABLE:

☐ **Attachment 10: Letters of Standing** – Official verification of professional licensure from each state or jurisdiction in which you now hold or ever have held a license must be included with your application. The letter of verification must include the current status of your license, your license number, the official seal and signature of the jurisdiction's licensing board and any disciplinary action taken. A photocopy of your out-of-state license is not acceptable.

☐ **Attachment 11: Practice History** - If you have ever practiced dentistry in another jurisdiction or state, please include a current copy of your resume, curriculum vitae or practice history.

☐ **Attachment 12: National Practitioner Data Bank Self-Query** - (Required if you have ever held a professional healthcare license elsewhere in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted with your application.